2011 Military Health System Conference

Uniform Business Rules, Process and Tools for Clear and Legible Reports/ROFR Reports for T3: The Planning Phase (Sept 09 to July 10)

Ms. Martha Lupo

27 Jan 2011

Deputy Director's "Top 10" Focus Areas for T-3 Transition

1. Prime Service Areas
2. Wounded Warrior Programs
3. Clinical Support Agreements and External Resource Sharing Agreements
4. Continuity of Care
5. DIACAP
6. Claims
7. Provider Relations
8. National Guard/Reserve
9. Clear and Legible Reports
10. Overseas Contract

Background

- Requirement for MCSCs to retrieve consult reports from network providers for the MTFs was a new feature in the TNEX contract.
- The rationale: MTFs historically have had difficulty getting results back from downtown providers.
- Controversial from two perspectives:
  - The MCSCs could not deliver the requirement as written (98% in 10 days/100% in 30 days) and the entire performance guarantee amount was spent on this requirement.
  - A third party between the referring and consulting providers was not normal industry practice.
- Requirement re-written – different in each region
- Decision to exclude in T3 made in 2005/6

Why is it necessary to obtain referral results (CLRs)?

- To manage the ongoing treatment of MTF enrollees sent for “evaluate” referrals.
- To have knowledge of the engagement and outcome of “evaluate and treat” referrals for enrollees.
- To meet Joint Commission standards to have a process for managing referrals and having results posted in the record.
- To meet Service inspection requirements regarding management of medical records.

T3 Transition Issue

- **The Managed Care Support Contractors obtain completed consultation reports, operative reports, and discharge summaries to for the referring MTF provider in the T-NEX contract.**
- **The CLR retrieval function is not in the T3 contract.**
- **What are the courses of action that can be taken to insure CLRS are returned to the referring MTF provider?**

MCSC CLR Workload (by Region and Consolidated … Minus Exclusions)

	Jan - Mar 2009	Apr - Jun 2009	Jul - Sep 2009	Oct - Dec 2009	Total Annual (#)	Total Annual (%)	Per Month (#)
Evaluate	**7,108**	**7,463**	**6,787**	**6,119**	**27,477**	**3%**	**2,290**
North	2,248	2,742	2,421	2,159	9,570	**1%**	**798**
South	3,749	3,647	3,151	2,798	13,345	**1%**	**1,112**
West	1,111	1,074	1,215	1,162	4,562	**1%**	**380**
Evaluate and Treat	**210,081**	**228,291**	**223,144**	**203,707**	**865,223**	**97%**	**72,102**
North	47,834	53,785	50,821	45,050	197,490	**22%**	**16,458**
South	70,231	74,377	73,957	68,041	286,606	**32%**	**23,884**
West	92,016	100,129	98,366	90,616	381,127	**43%**	**31,761**
Total N, S, and W	**217,189**	**235,754**	**229,931**	**209,826**	**892,700**	**100%**	**74,392**
North	50,082	56,527	53,242	47,209	207,060	**23%**	**17,255**
South	73,980	78,024	77,108	70,839	299,951	**34%**	**24,996**
West	93,127	101,203	99,581	91,778	385,689	**43%**	**32,141**

Source (TRO South Data): TIP Online: Performance Guarantee Report, ZSUMG818-1R

Source (TRO-West): PAT Referral Compliance Report

Source (TRO-North): PAT - Monthly CLR Report: Jan - Dec 2009 (CDRL: G0356aa)

Tiger Team Members

Core Team:

- Air Force Air Staff: Maj Ted Rhodes/Ms. Marissa Koch
- Army MEDCOM: Mr. Mike Griffin/Ms. Sonyo Graham
- Navy BUMED: LCDR Holder/Ms. Leslie Cohen
- TRO- North: CAPT Andrew Findley/CAPT Andrew Spencer
- TRO- West: Lt Col Gail Reichart
- TRO-South: Mr. Jim King
- JTF CAPMED: COL George Patrin

Consultants:

- Dr. Barry Cohen/Ms. Lois Krysa – Office of the Chief Medical Officer
- Mr. Karl Hansen – Legal Counsel
- Mr. Don Moulton/Bea De Los Santos – Contracting Officer
- Ms.. Dickie England – Systems Engineering
- Lt Col Susan Black, Ms Wollford-Connors

First Tiger Team Charter

- Inventory the current available models in use in the various regions
- Evaluate the opportunity for bi-directional exchange of CLRs (MTF to network and network to MTF)
- Identify best practices
- Formulate courses of action (COAs) with pros/cons and potential cost estimates
- Rank order the COAs
- Present the results at the JHOC (in 45 days)

Courses of Action

#1 The MTFs have responsibility for obtaining all CLRs using agreed upon standards, business rules, measures, metrics and reports.

#2 The MCSC have responsibility for obtaining CLRs. Require them to obtain all CLRs. Require the fax process be secure web-enabled and bi-directional. Use performance incentives rather than performance guarantees.

#3 A central contractor obtains CLRs and sends ROFR results. Uses secure web technology.

#4 Purchase a secure web functionality to enable bi-directional flow of referrals, consults and other medical information for MTF use.

Subsequent cost and feasibility analysis supported COA #1

Second Charter

- **Develop standardized business rules, standards, and reporting metrics**
- **Identify the supporting database, tracking and reporting tools**
- **Identify the minimum human resources needed to handle the increased CLR workload**
- **Identify the timeline to complete necessary training and implementation by start of health care delivery**

Business Rules in Brief

- There will be a single, accountable site for tracking and managing CLRs and ROFRs and that is the Referral Management Center/Office (RMC/O)
- All referrals to network will be tracked in the Integrated Clinical Database System (ICDB) as the interim, enterprise database solution
- All referrals to network will have a UIN and an auth number
- All referrals will be made via a HIPAA compliant method (fax or electronic)
- The MCSC will provide the name of the network provider referred to
- Joint Commission and other Service regulatory rules apply
- Single phone, fax, address, email, mailing address for RMC/O

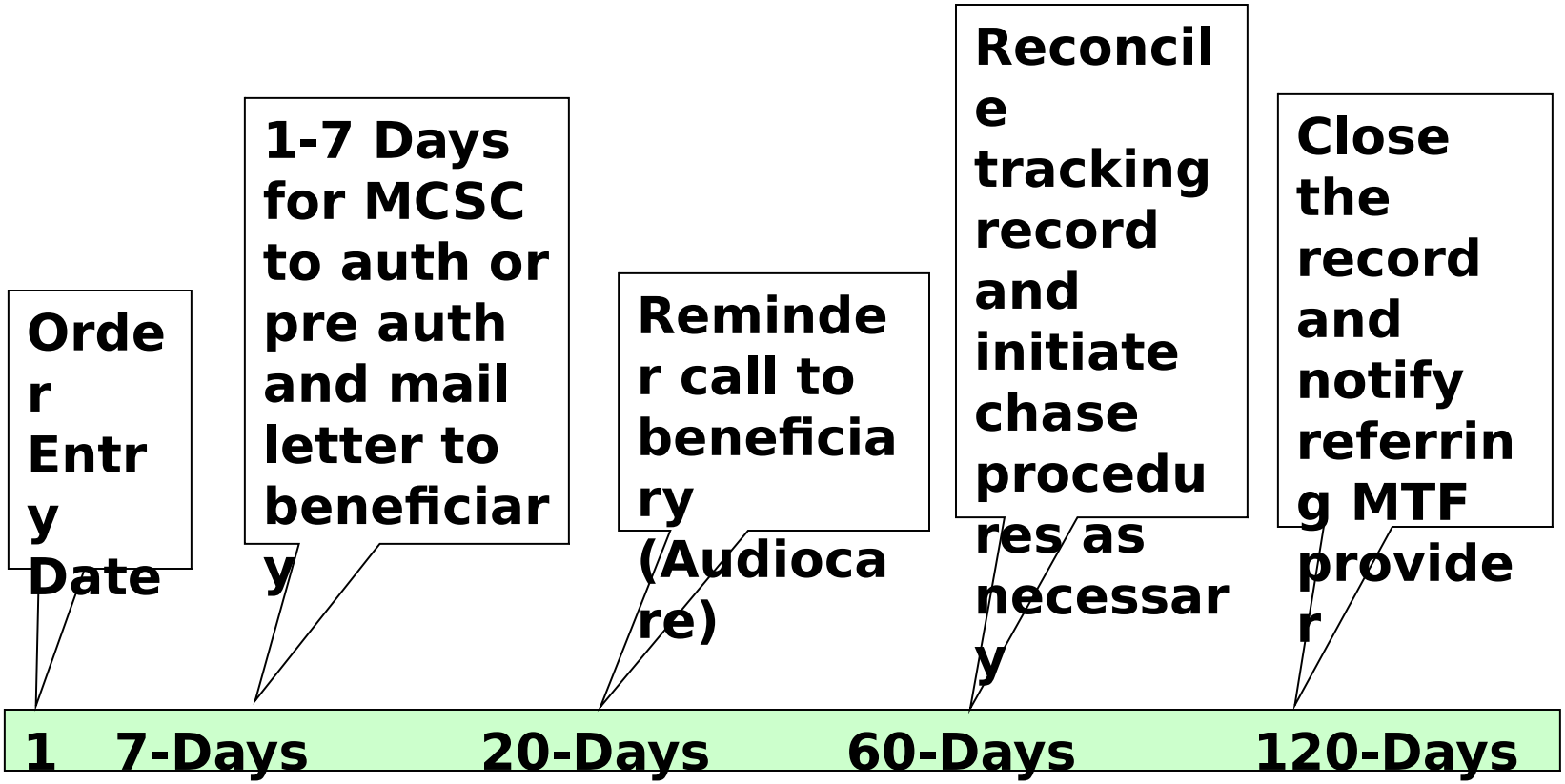
Business Rules (con't)

- Beneficiaries will receive an electronic **phone reminder** message 20 days after order entry date
- CLRs for **DME and hospice** will be by request only
- CLRs are **reconciled** in the tracking database w/i 3 days of receipt – **results go** to provider or posted in AHLTA
- RMC/O staff will begin a **"chase"** for results if not received by **60 days** after order entry date unless requested earlier

Business Rules (con't)

- **"Chase" involves the following procedures: checking inbox, check claims database, call beneficiary, call/fax MD's office**
- **Close with note to provider at 120 days if no CLR (will require reset of admin closure from current 30 day setting)**
- **With ROFRs, results sent to network provider w/i 10 days of MTF appointment, internal chase procedures established, notify network provider if no appointment w/I 120 days**

Flow Model for CLR Management



Enterprise-wide Interim Electronic Solutions

- **Integrated Clinical Database (ICDB) is the interim solution until the Electronic Health Record (EHR) is available**
  - Air Force product
  - Funded for those sites that do not currently have
  - Fully deployed for Army and Air Force.
  - Air Force has used for the past several years
- **Referral Management System Tracking and Reporting (RMSTR) – ICDB software – will be used for tracking and reporting**
  - Same as above
- **AudioCARE Systems Communicator - DM**
  - Uses an ad hoc report generated on CHCS to compile the list of patients to be called
  - Funded for all sites

Training/Staffing

- **Training and execution timelines established in North Region**
  - **Train on ICDB/RMSTR – trainers funded and online training available now**
  - **Training on the business rules and AudioCARE**
  - **Staff fully trained and ready to manage CLRs by Jan 2011 – go live 1 Apr 2011**
  - **South and West Regions: To be trained and ready 2 months prior to start of health care delivery (TBD)**
  - **Services have the primary responsibility for training and staffing**
- **Staffing**
  - **Funded for current year and POM'ed for 2012**
  - **Resource intensive!! Consolidation desired in areas where practicable as soon as possible.**

Moving from Planning to Operations

(July 2010 - onward)

CAPT Yvonne Anthony

TMA CLR Program Manager

Planning to Operations

- Planning
  - North Transition
  - OCONUS
  - South/West
  - Policies in place

- Operations
  - Standardize tools
  - Functional requirements
  - On-going meetings with Tri-Service

Point of Contact

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Referral Management Process
The Referral Management Office (RMO) Perspective

Sonny Graham
ARMY MEDCOM, CLR Tiger Team
TRICARE Management Activity

January 2011

The RMO Perspective

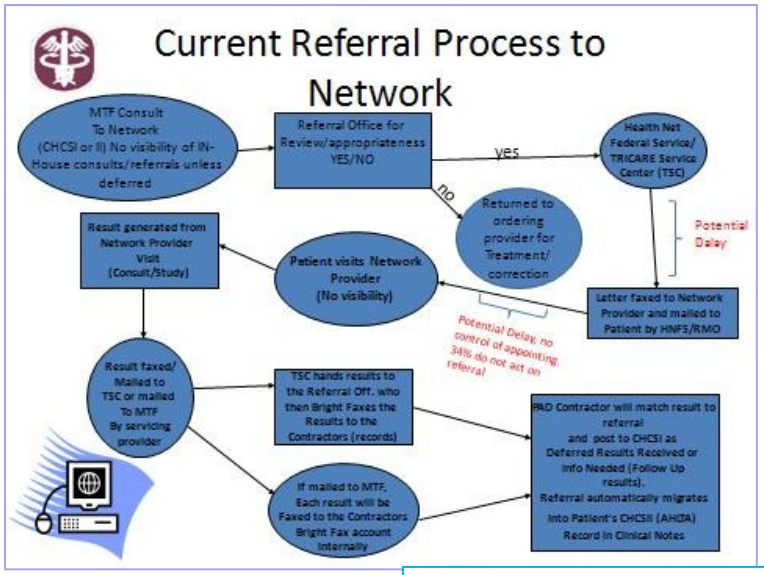
1. Sub Work Group
2. Uniqueness –*Tools, spools, and best practices/local efficiencies; Oh My!!!*
3. RMO Process(es) – *Validating chaos*
4. What is the benefit

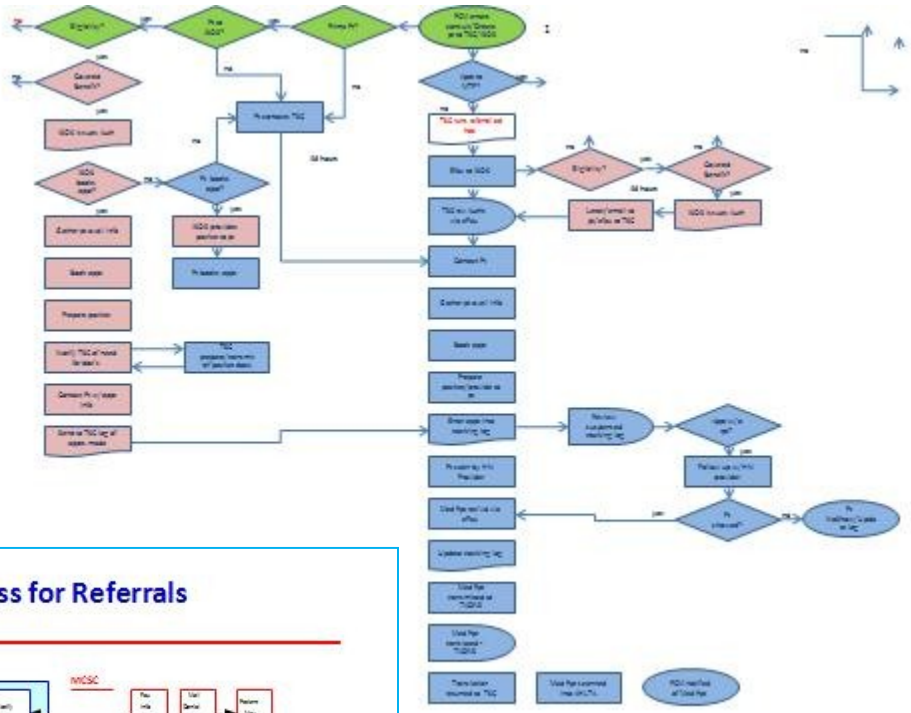
RMO “Uniqueness”

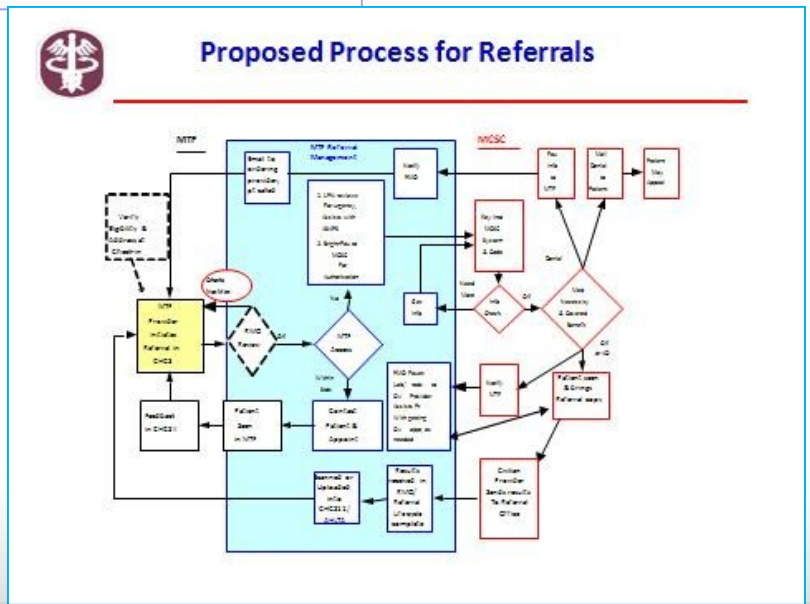
Uniqueness has been identified in the reporting requests to MTF Command

- Access
- Monarch
- WRMCs e278
- Excel Spreadsheets
- Pencil/Paper tracking

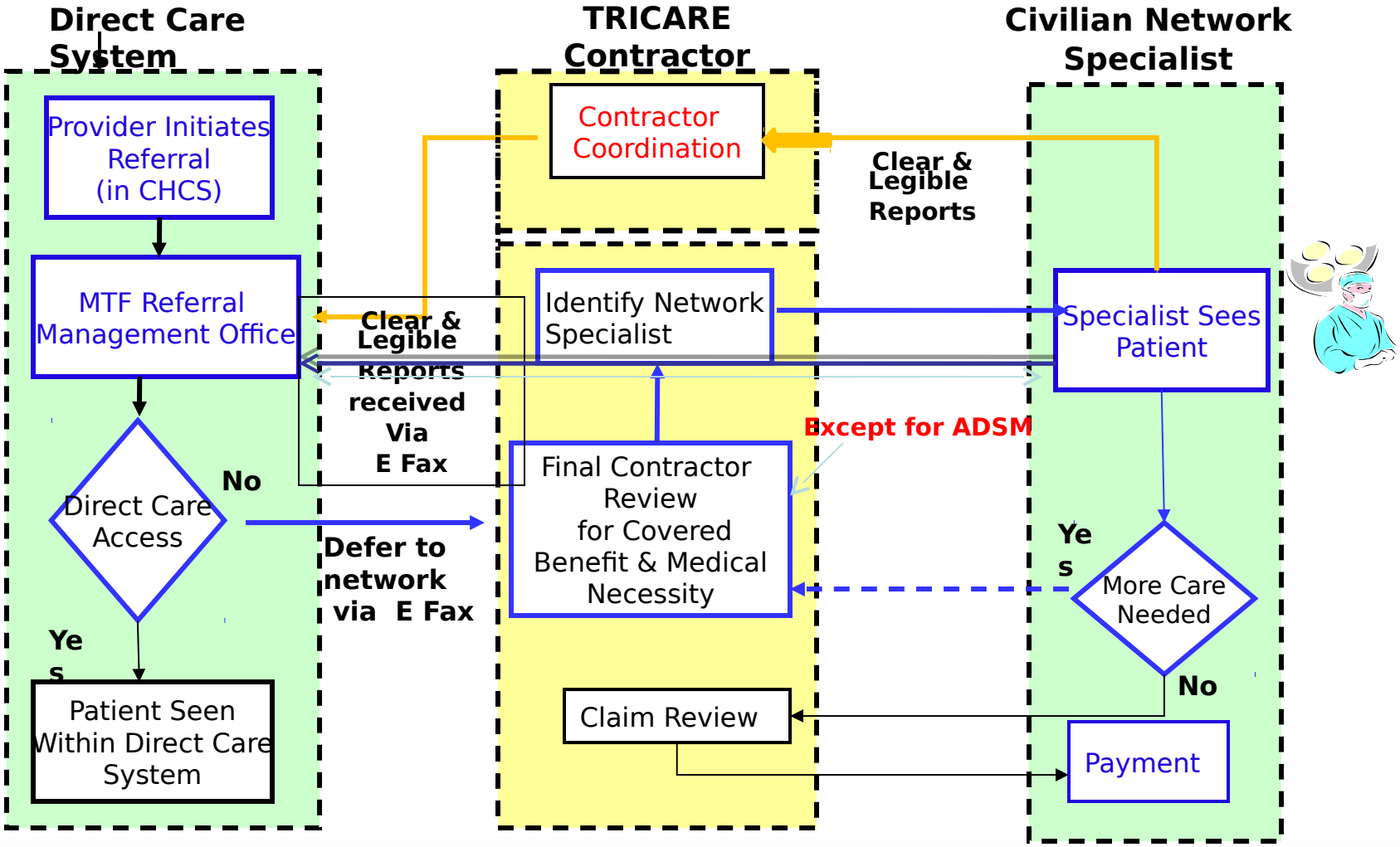
Uniqueness Identified in Process







Front to Back End



The RMO Purpose

- To manage the ongoing treatment of MTF enrollees sent for “evaluate” referrals or for clinical ancillary testing.
- To have knowledge of the engagement and outcome of “evaluate and treat” referrals for enrollees.
- To meet Joint Commission standards to have a process for managing referrals and having results posted in the record.

Roles and Functions of the Referral Management Office

- MTF referrals are coordinated through a single entity known as the Referral Management Officer (RMO)
- Responsible for processing, tracking and reporting all referrals and their results
- RMO processes, tracks, and coordinates defer to network referrals with the TRICARE Contractor
- Source for internal and external Referral Management Process
  - MTF provider sending referral to civ network specialist
  - Civ Network specialist sending results to MTF provider
  - Civ Network provider sending referral to MTF

Roles and Functions of the RMO

- Identify trends, recapture care, meet capability needs by managing ROFRs, and promote continuity of care
- Ensure referral results are captured and placed in the beneficiary medical record
- CHCS / AHLTA is used to generate and result referrals
- Manage the MTF's Right of First Refusal (ROFR) process
- Dedicated to quality, cost, access, and outcome
- Be prepared for OIP Inspections
- Staffed with both Clinical and Administrative members

The Benefits

- Corporate and Enterprise
- Business Rules
- Multi Service Market Office Consistency
- Portability
- Standard Reporting Metrics
- Ongoing RMO training

Clear and Legible Reports: Air Force Challenges and Actions

Major Ted Rhodes
CLR Program Manager

Air Force Business Rules-Staffing

- TMA Business Rules incorporated into AFMS Referral Management Guide v7.0 in April 2010
- North Region
  - Money Received from TMA for FY11 in FY12 POM
  - Staffing provided via Air Force Commodities Counsel Spiral 2 Task Order
- South and West Region
  - Programmed in FY12-16 POM
  - Tasking Order will be accomplished via

Air Force Technical Solutions

- Referral Management System Tracking and Reporting (RMSTR)
  - RMSTR 1.2 (Tri-Serve enhancements) still in development
- Referral Management System
  - Automated system of sending defer to network requests to TRICARE contractor
  - Fax method 5 cents CONUS/7 cents OCONUS
    - $80K annually for CONUS referrals (1.6M annually)
  - E278 XML takes the required data points and transmits in XML format
    - No additional cost!
- Referral Management Program Management Tool (RMPMT) – In Development

Air Force SMEs

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Clear and Legible Reports: Navy Medicine Challenges and Remedies

LT Adam Rae, USN, MSC
Bureau of Medicine and Surgery

Navy Medicine's Challenges

- Authorized to Operate (ATO)
- Identifying Stakeholders
- Identifying Stakeholders Roles and Responsibilities
- Establishing Communication Among Stakeholders
  - M3/5;M6;NAVMISSA/Region/MTF
- Sense of Urgency

Navy Medicine's Remedies

- **BUMED CLR Workgroup**
  - **M1(HR); M3/5 (Medical OPS); M6 (IT); NAVMISSA;TRO-North; Navy Medicine Regions; MTFs; Ad-hoc members**
- **Effective Coordination with M6 and NAVMISSA**
- **Effective Communication with Navy Medicine Enterprise**
  - **Presentations to CEB; Regional COS; MTFs**

Clear and Legible Reports: The North Region Engagement in Preparation for Transition to the T-3 Contract

CAPT Andy Spencer
Chief, Medical Management
North Region CLR Champion

Preface to Official TRO Role

- **Planning the implementation of the CLR Tiger Team recommendations—a/k/a blazing the trail**
  - **Engagement with Services for ICDB roll-out in North MTFs**
  - **Promote communications on CLRs within regional multi-service markets**
  - **Analysis of CLR workload performed by the MCSC for TMA manpower supplementation**
    - Tri-Service membership & agreement
    - Joint Health Operations Council approved
    - 44 FTEs total*: Army-20; Air Force-12; Navy-11

*One FTE of workload was USCG that TMA does not resource under the DHP

The Task

Only two high-level tasks:
Transition In and Out

- **Transition Out**
  - **Get the group together to plan and coordinate [+/- 35 members]**
    - **TRO Subject Matter Experts**
    - **Contracting**
    - **Intermediate Commands**
    - **TMA & other Regional Offices**
    - **Outgoing Managed Care Support Contractor**

Transition Out

- Coordinate
  - Varying Services, intermediate command and MSM amplification
  - Statuses and news: often an information broker
- Educate
  - Differing disciplines
  - What will the effect be?
  - How was business done before?
  - Business processes of others working CLRs
- Plan
  - Transition of previous centralized functions
  - Site-by-site, fax line-by-fax line
  - Map the “as is” and “to be” states
  - Allow for time for any changes
- Track, track, track
- Readiness assessments and leadership updates: will we make it?

Transition In

- The incoming contractor has no responsibilities for chasing CLRs
- Ensure CLRs erroneously provided to the MCSC get routed where they need to go
- Provider network handbook/agreement expectations
- Coordinate referral/authorization letter
- Educate providers
- Educate MTFs

Post Hoc Realizations of the Blindingly Obvious

1. Many MTFs did not have sound processes for CLRs
2. CLRs have been consistently the a top T-3 transition concern of MTF Commanders
3. Interested individuals will obtain information from any source if not pushed-out to them
4. There are a lot of CLR transition planning groups (I attend four alone). Similar issues at varying levels and organizations

Post Hoc Realizations of the Blindingly Obvious (cont.)

5. CLRs are cross functional:
   - Referral Management
   - IM/IT
   - Contracting
   - Patient Administration/Medical Records
6. The devil is in the detail:
   - Tracking to the baby DMIS and individual fax line-level
7. Where referral management performed not imply where CLRs are or will be returned
8. Many believed CLRs exclusively a MCSC responsibility vice a Joint Commission/AAAHC requirement of MTF
9. CLR planning is a lot of work

Point of Contact

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Main Points

- The process of planning for the transition of CLRs (consult reports) was described.
- The transition to operations, particularly challenges and actions, was described from the Service perspective.
- A view of actual transition of the CLR process in the North was presented.